JOURNAL of MAINE EMS

JANUARY 2009

INSIDE:

BY JAY BRADSHAW, EMT-P
DIRECTOR MAINE EMS

Making a Difference at the Local Level

It's for the children.

I have been interested and involved in town government for a long time, as is my father, as was my grandfather. Whether as part of the rescue squad, Board of Selectman, Budget Committee or Town Moderator (my latest role), this is a front row seat to how things happen and where involved individuals can have a substantive impact.

To be sure, there are plenty of mandates that come down from the federal and state levels over which we feel helpless, and underfunded. But there are also the items on the Town Warrant that get to the root of who we are as a town and the things we feel are important.

It is at the local level where one person can have an idea that blossoms into a project such as a community center, public library, rescue squad, or food pantry. It is at the local level where neighbors look out for neighbors during ice storms, fires, and serious illness. It is at the local level where one person reaching out to help another can change a life.

As EMS providers we know this, and we live this.

Those of us who have been doing this for a while have seen many changes in our careers. EMT classes that were once only taught at places like Harvard University over the course of a couple weekends now take place all across Maine and go for a semester, and more.

In those early days, "Bag and drag" was not just an expression, it was more like a protocol (to the extent that there were what we now know as protocols). Almost regardless of the patient's age, the goal of the ambulance was just to pick them up and give them a horizontal ride.

What a difference a few decades make.

We know that EMS can, and does, make a difference each and every day. Our education and treatment options today include a much more robust understanding of patient needs – and not

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Cover photo by Dan Limmer.

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just in a generic sense; our ability to recognize that different age patients have significantly different normal ranges, and needs.

Nowhere is this more visible than with children. It's probably been 20 years or so since I first heard the expression that children are not just "small adults" and today we have many excellent programs that provide the training and education we need to adequately care for these patients.

Programs like PEPP, PALS, and PEARS (if you're not familiar with these acronyms, it is worth talking with your regional EMS office to learn more). These are programs that don't just include a segment on caring for children; the entire program is about caring for children and includes BLS and ALS.

In 1993, the Institute of Medicine (IOM) released its first report on EMS for Children. The IOM Committee was charged with reviewing the nature and extent of pediatric emergencies and to define the characteristics of an EMS-C system. Their recommendation was that "…all state regulatory agencies with jurisdiction over hospitals and emergency medical services systems require that hospital emergency departments and emergency response and transport vehicles have available and maintain equipment and supplies appropriate for the emergency care of children." (Emergency Medical Service for Children, National Academy of Sciences, 1993)

Projects in Maine that were developed and supported by EMSC include: Youth Suicide Gatekeeper Training, Playground Safety, EMS Expo, MEMSRR, and this Journal of Maine EMS. EMSC has, and continues to provide a subsidy for EMSC training.

But this entire system of care begins at the local level with EMS providers who respond to the calls, talk to children in schools, conduct safety fairs, inspecting playgrounds, and make a very real difference each and every day.

MEMSRR

January 1 marked a significant date in Maine EMS history, because that is the date by which all services were to have switched from our old paper forms to the new electronic data collection system, MEMSRR.

This change has not been swift and it has not been easy, but it has been (and continues to be) one of our most ambitious and important projects.

Ambitious because it seems that change is sometimes viewed as inherently bad to some. I've been around long enough to remember many versions of the paper run forms and the resistance that brought. Eliminating the paper form is like tossing out an old pair of jeans, even if they no longer fit.

Prior to launching MEMSRR on January 1, 2006, we encountered vocal opposition from some who are now passionate supporters. One service chief recently acknowledged that this system provides him with an invaluable business tool – one that he would not be without.

It is still not easy for some, but with time MEMSRR is becoming more comfortable for all. We appreciate your support and your feedback.

See you in a few months.

Pediatric Patient Transport

Sally Taylor, EMT-P

When you have a pediatric patient in your ambulance are they properly restrained? If not, can this be improved? In guidelines issued December 1, 1999, EMSC estimated that approximately six million children are transported annually by EMS vehicles in the United States. At that time the guidelines recommended do's and don'ts for transporting children in an EMS vehicle. The do's are a fairly common sense list, but warrant a review. Drive cautiously at a safe speed, tightly secure all equipment, ensure available restraints are used by all occupants to include the EMT and the patient, and encourage utilization of the NHTSA EVOC course. They also encourage children who are not patients be transported by other means, properly restrained, when possible. The don't side is also a list of common sense items. Don't drive at unsafe high speed with rapid acceleration, decelerations, and turns. Also, don't leave equipment unsecured, don't allow any occupants to be unsecured, do not have the child held in the parent, caregiver, or EMTs lap during transport, and do not allow emergency vehicles to be operated by persons who have not completed DOT EVOC or the equivalent.[1]

The question, then would remain, what is proper restraint for a child in an EMS vehicle? In a paper, "Crash Protection for Children in Ambulances", by Marilyn J Bull, MC, et al, it states "effective restraint is dependent not only on the child restraint equipment but also on the platform to which it is attached." The patient care compartment generally is similar in ambulances. There are bench seats, a rear facing chair, a cot mounted to the floor, and storage compartments. There are generally no forward facing seats in the patient care compartment, which are where most child restraints should be installed per

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Pediatric Patient Transport

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manufacturer directions. Children who are being transported for medical reasons are generally transported restrained directly to the cot, though this provides little crash protection. A rear facing captain's chair can provide a good platform and special directions may be available from manufacturers for installation of convertible car seat models. Some rear facing captain's chairs also come with a built in child restraint. Installations of a child restraint seat on the bench seat in a side facing position are specifically prohibited by all car seat manufacturers.[2]

In the study done by Marilyn Bull, MD, et al, a series of crash tests at 30 mph using infant, 3-year old, and 6-year old dummies were conducted. For restraints systems they used convertible child restraints, car beds, and harness systems. They varied belt configuration and backrest position. It was determined that a two-belt attachment with an elevated cot backrest was the method with the least performance variability. One confounding factor in this was the cot cushion that compressed and shifted during impact, making the job of the harness more difficult. The study also concluded a new cot and slide in track fastener system improved restraint performance over the older antler systems. None of the installations proved to have ease of use and effective restraint.[2]

Several recommendations arose from the Marilyn Bull, MD, et al study. These recommendations were not specifically endorsed by any child restraint manufacturer and the recommendations may not be consistent with instructions for use of a child restraint system. Recommendations for restraining a child up to 18 kg who can fit into a convertible seat and tolerate a semi upright position include, using only a convertible seat which can be secured with belts against both and rear motion and has a five point harness. Position the convertible seat on the cot facing the foot end with the back rest fully elevated. The back surface should fit snugly against the cot, with the resulting angle being comfortable for the child, but no more than 45 degrees from vertical. The convertible child seat should be anchored using two belts. One should be attached to the cot backrest in a location through the belt path marked "forward facing" installation. The other should be attached rearward of the farthest side rail anchor and routed through the restraint belt path marked "rear facing" installation. The five point harness should be fastened, snugly adjusted to the child, with the shoulder straps through the slots at or just below the child's shoulders. Small infants may need rolled towels or blankets may need to be placed on either side of the child to keep them centered. Infant restraints can not be installed using this method as they only have a single belt path. For infants who can't tolerate a semi-upright position or who must lay flat a car bed system is recommended. The car bed used must have two belt paths to protect against both forward and rearward motion. A car bed with a single belt path may not be installed in this method. Position the car bed across the cot, so the child lies perpendicular to it, and fully elevate the backrest. Restrain the car bed with two belts attached to the cot. Fasten the harness and snugly adjust. No recommendations came from this study for restraining a child who can't be transported in a convertible child restraint or car bed, either due to size or their medical condition. Recommendations were made however for the design of an effective harness for use on the ambulance cot. Harness features recommended were fixed shoulder belt attachments or slots at or just below the child's shoulders to limit ramping. They also included a belt anchored to the lower side rails of the cot that won't slide and is routed over the thighs and not the waist and a belt running parallel to the cot that connects the lap belt to a non-sliding cot member or perpendicular belt in the leg area to keep the lap belt in place and restrict ramping. A soft, sliding, or breakaway connector holding the shoulder straps together on the chest and lightweight one handed strap adjusters were also recommended.[2]

This study by Marilyn Bull, MD et al, has been considered the golden rule among EMS services since it's publication in 2001 per the position statement of the AAMS. New innovations and restraints have been implemented but have had limited crash testing due to the lack of federal guidelines for their use.[3] EMS services may or may not have developed their own policies and procedures for transporting pediatric patients. If your service does not have a policy for restraining a pediatric patient during transport, now may be the time to develop it.

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Maine Medical Center Completes Phase I of New ED with an Eye on EMS

Michael A. Gibbs, MD, FACEP
Professor and Chair, Department of Emergency Medicine, Maine Medical Center
President, Maine Chapter of the American College of Emergency Physicians

It has been almost a year since I first shared our plans to expand and renovate the Maine Medical Center Emergency Department with you. On December 2, 2008 we will welcome our first patient to the new facility. This represents the completion of Phase I of the project, i.e.: the opening of new clinical space in the recently constructed East Tower. Phases II and III, that will proceed during the ensuing nine months reflect renovation of our existing clinical space. When all is said and done next September 2009, our footprint and room count will double and the citizens of Southern Maine will enjoy a new state-of-the-art facility.

As you will see below, the opening of Phase I will offer significant enhancements to EMS providers across the region that "begin at the front door." Before enumerating these, I should point out that our total patient room count will not increase until Phases II and III have been completed next summer. Until then our entire staff will work hard with you to provide care in less than ideal surroundings. We very much appreciate your collective patience and support as we move through this important transition together.

Now for the good part; allow me to walk you through the Phase I facility, pointing out a few major highlights…

No more parking in the rain. Ambulances will now park under cover of our new building with significantly more vehicle capacity. You and your patients will be protected from the elements; ambulance exhaust will be vented by special air-handlers, and wireless electronic equipment will remain enabled. Additional dedicated ambulance parking is provided adjacent to the Emergency Department ambulance entrance.

Rapid, high-volume patient decontamination will now be possible. Our decontamination capabilities have been completely redesigned to accommodate everything from the isolated exposure to the mass-casualty event. An outdoor decontamination facility with retractable partitions will allow for the independent and private decontamination of men, women, and those with critical needs. A contained indoor decontamination room provides additional support for these unique and challenging circumstances.

REMIS gets a face-lift. The talented staff at REMIS/OneCall provide excellent service, but do so in a very cramped environment. The new REMIS facility is significantly larger; allowing our EMS tele-communicators to work efficiently without distraction. Communication and database equipment will be state-of-the-art and we will continue to play a major leadership role with all prehospital activities in the region.

Welcome to the new world of bedside registration. Along with the physical growth of our department, we have also invested significant efforts on process improvement. Triage will be streamlined and 100% of our patients will be registered at the bedside. What this means to you is less time waiting and a more effective patient care transition with our clinical staff. When Phases II and III of the renovation are complete in September and our capacity is maximized we believe the wait for a treatment space will be completely eliminated.

No more parking in the rain. You and your patients will be protected from the elements; ambulance exhaust will be vented by special air-handlers, and wireless electronic equipment will remain enabled.

Critical Care and Acute Care space to be proud of. Perhaps our pinnacle achievement; the opening of six state-of-the-art Critical Care treatment rooms and twenty-four fully monitored Acute Care treatment rooms will allow us to manage your sickest patients rapidly and safely. We are moving to a new paradigm that includes all private rooms, uniform treatment space design, bedside computers, and much improved clinician work space.

Compassionate care of patients with psychiatric emergencies. Patients with psychiatric emergencies have unique needs and pose unique challenges to the healthcare system. Our new facility will include a dedicated ED Psychiatry unit with six private treatment spaces and ample room for our staff to provide excellent care.

Comprehensive Emergency Department imaging. As you know, CT scan imaging has proliferated at a dizzying pace. This is especially relevant in the care of patients with "time-sensitive" medical conditions like trauma and stroke. The new ED will include a new 64-slice CT scanner, with room for a second scanner as our patient volume grows.

Now that your patient is safely in our hands, have a seat! **A brand new EMS Room** [adjacent to REMIS] will provide dedicated space for you to get your charting done online, make phone calls, or simply take a breather with a hot cup of coffee. We are very proud to offer this enhancement to you and the entire EMS community.

As I mentioned, we are not quite done. During Phase II we will renovate our existing treatment space; creating a large facility for the care of ambulatory patients. There will be space for children; increasing the size and scope of our Pediatric ED. In addition, we will create an 8-bed Clinical Decision Unit that will allow us to deliver longitudinal care to a large number of patients with specific medical conditions. During Phase III our ED Waiting Room will be completely renovated.

It is with great pride that we share this exciting news with you. This represents the culmination of a five year project and a tremendous investment by the medical center. We look forward to sharing our new home with all of you.

Colors, Weights, Math, and Sizes:

Use of Pediatric Resuscitation Aids in EMS

Let's face it- most of us are scared silly by pediatric calls. Ages, stages, regression, developmental delays, and individual variability in size, behavior, and vital signs. Mix them together and you have a huge degree of apprehension for most health care providers about caring for kids.

Across the country, the average EMS provider is involved treating pediatric patients in about 5-10% of their total annual EMS responses, with critically ill and injured kids accounting for only a small percentage of this total number. The current standards in place for pediatric education during licensure programs vary widely between responder levels and locales. The net result is little exposure to a complex subset of patients that challenges us physically, psychologically, and emotionally. It is in the face of the many differences among kids and the knowledge and experience needs of the providers who care for them that several different "resuscitation aids" have been developed to help us treat patients effectively and more importantly, to keep these precious patients safe.

"Children are not simply little adults" is a phrase most of us have heard in every pediatric education program we attend. However, what does that truly mean? Simply, children differ from adults in two major areas- physiologically and psychologically. The equipment, supplies, medications, and procedures we use to treat them are tailored to the individual patient- their sizes, weights, age, developmental level, etc. Caring for pediatric patients requires a comprehensive approach by every member of the healthcare team that takes the individuality of the pediatric patient into account. While most providers are able to comfortably manage a 50 year old, 100 kg adult having an asthma flare they cringe at the thought of intubating, starting IVs, giving meds, and ventilating a 20 kg, five year old. How does one have confidence in treatment (recognizing that comfort is an elusive goal for most of us in the pre-hospital arena when it comes to treating sick kids)? The solution lies in using a resuscitation aid or aides to help augment common sense and critical thinking.

Length-Based Resuscitation Tapes

The proverbial quandary in caring for kids is the fact that almost everything is based on weight instead of age. Initially developed by Broselow, Luten, et al., the infamous Broselow™ Tape and later the Broselow-Luten Resuscitation System™ provided a series of color bands that matched up with weight ranges. For the BLS provider, often you are instructed just to "get a color and report it". Why is this important? I'll answer that shortly. For now, just remember that all length based tapes on the market estimate the child's weight based on length. The assumptions used in constructing the tapes are sort of like the dreaded tables used by life insurance companies- they are normed on the 50% for children in the sample population for that particular height. Broadening the weight into a color range band allows a reasonably safe estimation of weight plus or minus 2 kg.

Two problems emerge with this technique. First, we know that childhood obesity is an epidemic in the US. Does this lead to a gross underestimation of weight in obese kids and does this matter? Several recent studies have looked at this. The answer is except for a very few circumstances in critical care, medication dosing is usually based on ideal body weight and the estimation provided by any of the resuscitation aids is adequate for emergencies. The second issue is that used correctly, the tapes go by length, not height. This design feature is important since use of length-based tape on a child who is not supine may over or under estimate his/her weight. However, the variability in the tape will probably place the child in the same or an adjoining color band and estimate a weight that is safe for the child.

What is on the tape and why should I use it in EMS?

The exact contents of the tape vary by manufacturer. Typically, every tape consists of normal pediatric vital signs for a given weight; BLS and ALS equipment sizes from what size oral airway does a 5 kg infant take to what size chest tube does a 50 kg teenager need; CPR and BVM rates, IV fluid boluses precalculated in milliliters to infuse per bolus, and medication dosages. While the tape does contain a lot of "ALS" information, it is not an ALS-only device. All BLS providers should learn how to use it correctly, practice regularly

with it, and review what information is on it. The BLS information is crucial in pediatric care because it is the basis on which everything else depends- aggressive, appropriate management of the ABCs.

Additional variants on the tapes have become available in the last few years. The Pedi Wheel™ provides much of the same information but depends on the provider knowing either 1) The child's age or 2) The child's weight in order to turn the wheel to the correct setting and access the information for that patient. The "slide rule" variant (PEDI Slide ChartTM) includes a paper tape measure and allows providers to measure the child in centimeters if weight is not known or move directly to a weight range if a weight is known and then access similar data as the other devices specific to that child's weight in kilograms. One advantage of this device is its two additional scales for under weight and obese children that is intermeshed with the color ranges to allow a better fit for equipment and more accurate medication dosing.

Other Resuscitation Aids

One often-overlooked resuscitation aid for pediatric patients is only as far away as your 2008 MEMS PreHospital Treatment Protocol book. The 2008 edition, while not including the color bands (these are proprietary), features an expanded and revised medication section along with tables of vital signs and other equipment sizes (see Pink and Gray sections). Other aids include handouts from the TRIPP (Teaching Resources in PreHospital Pediatrics) curricula and numerous others.

Conclusion

Being able to adequately care for a seriously ill or injured child begins with calm and confident caregivers. Since these situations are challenging for all involved (patients, parents, and the EMS responders), simplifying the tasks of resuscitation through the use of a quick reference helps to eliminate errors and gives confidence to the providers that they have an additional resource to use during an unfamiliar call. Sick kids deserve the best care we can provide; with a little preparation and hands-on training with resuscitation aids, any EMS provider can provide quality care.

For more information on the Broselow-Luten SystemTM, see www.colorcodingkids.com

Armstrong Medical Industries is the official distributor of the BroselowTM Pediatric Emergency Tape. Visit their website at http://www.armstrongmedical.com/index.cfm/go/product.detail/sec/3/ssec/14/fam/150

A full history and description of the Broselow Tape is available on the above the color coding kids website.

The Pedi-Wheel™ is a product of EMS Advantage, Inc. A second version, Pedi-Wheel First Responder, is also available. See the company's website at http://www.emsadvantage.com/html/prodpw.html

The PEDI Slide CardTM is a product of A.C.T.N.T. Healthcare Services, LLC.

Kids Inhaling

Right Under Your Nose

Kelly Roderick, Maine EMS for Children Chair, Maine Inhalant Abuse Prevention Trainer

The challenge before us here in Maine is to address the use of inhaled substances by our middle school and high school aged students. According to the 2008 Maine Youth Drug and Alcohol Use Survey, almost 11% of Maine's 6th-12th grade students reported that they have abused inhalants in their lifetime. Inhalant abuse is an often-overlooked form of substance abuse, which can have serious consequences including damage to the brain, liver, and kidney not to mention death. Sudden Sniffing Death Syndrome is a known result from kids and adults who intentionally inhale a product to get high, and it can happen the very first time they try. Unlike alcohol or illegal drugs, inhalants are convenient, legal to purchase, and often times free, including the more than 1,400 common items easily accessed in the kitchen, garage, office, and at school.

Maine Inhalant Abuse Prevention Work Group has arranged formal training for professionals titled "Inhalant Abuse: It's Right Under Your Nose." The goal of this training is to acquaint participants with the nature and patterns of inhalant abuse and provide them with effective prevention and assessment strategies, tools, messages, and resources. This training is available on three dates in three different locations: April 15, 2009 at Franklin Memorial Hospital in Farmington; April 27, 2009 at Spectacular Events Center in Bangor; and April 29, 2009 at Trade Winds in Rockland.

Join us and help stop the spread of this epidemic. Help us spread the word, get more folks involved and save our kids. You can also visit the Work Group at their website: maine.gov/dhhs/osa/prevention/community/inhalant.htm.

CEH Corner

Once you have finished reading and understanding this issue's article on Pediatrics you can complete the following 5 questions which pertain to the subject matter. Submit your answers by mail or electronically to MEMS Journal Kelly Roderick 141 Fairfield Street Oakland ME 04963 kr8264@gmail.com. Your name and license number will be submitted to Maine EMS for credit and will appear directly on your MEMS CEH Report. Your completed questions must be received no later than February 20, 2009 to receive your 0.5 hour in Cat 2 BLS Topics 0.5 hour in Cat 4 ALS Topics

NAME _____

EMS or EMD License Number _____

1. Length-based resuscitation tapes provide BLS providers with useful information including:
   a. Patient weight
   b. Age-appropriate vital signs
   c. Sizes of BLS airway adjuncts
   d. All of the above

2. According to the 2008 MEMS Protocol book, the systolic BP for a preschooler is:
   a. 95-105 mm Hg
   b. 96-108 mm Hg
   c. 112-128 mm Hg
   d. 50-90 mm Hg

3. Length-based resuscitation tapes use the patient's length to represent height and from this, an estimate of:
   a. Weight in kg
   b. Weight in pounds
   c. Height in inches
   d. Age in years

Question 4 & 5 require the use of a length-based resuscitation tape or other resuscitation aid.

4. You are dispatched to a 4 year old with trouble breathing. She falls in the yellow band on the tape when you measure her with an estimated weight of 29 pounds (13 kg). What is the correct size oral airway for this patient?
   a. 50 mm
   b. 110 mm
   c. 60 mm
   d. 80 mm

5. The patient in number 4 requires defibrillation and the paramedic asks you to check the dose on the tape for an initial shock of 2 J/kg. What energy level in Joules should the paramedic shock this patient at?
   a. 52 J
   b. 26 J
   c. 100 J
   d. 200 J

Maine Emergency Nurses Association

Tammy Lachance, RN, BSN, CEN
Central Maine Medical Center

ENA REPORT ON ROADWAY SAFETY LAWS – Maine is at top!

In November 2008, the Emergency Nurses Association released a detailed report on the strengths and weaknesses of every state based upon the existence of roadway safety laws in that state. Each of the 13 laws examined in the report are research-based and have been shown to save lives.

Per ENA, "The 2008 ENA National Scorecard on State Roadway Laws: A Blueprint for Injury Prevention is an update of its predecessor, the 2006 ENA National Scorecard on State Highway Laws. This ENA advocacy effort is designed to reach lawmakers via the public. The scorecard aims to advance evidence-based prevention interventions and laws to enable better understanding of acceptable risk, of making smart and informed decisions and of implementing reasonable precautionary measures."

The scorecard focuses on six general issues that are under state jurisdiction:

- Primary enforcement of seat belt use
- Child passenger safety laws
- Graduated driver licensing
- Motorcycle helmet requirement for all riders (driver and passenger)
- Ignition interlock device usage for hard-core drinking drivers
- Legislation to enable the creation of a statewide trauma system

Based upon this scorecard, Maine is in four-way tie for second place for our state's commitment to roadway safety! Only two states, Oregon and Washington, received the best possible score of 13. Maine, along with California, District of Columbia and Tennessee, scored 11 out of 13 points. Interestingly, the two missing points were different for all four of the states that tied for second place. Maine lost two points for the lack of a universal motorcycle helmet law requiring all riders to wear a helmet and the lack of a law requiring motorcycle helmets to met federal protection standards. Maine was also recognized in this report for having improved our score by three points since 2006. This report shows that we can be proud to say that we live in Maine, a state that cares about our safety.

The 2008 ENA National Scorecard report is available at http://www.ena.org. Summary reports and a sample press release are also available. Check it out!

NEW BOARD MEMBERS

Congratulations to the following emergency nurses who are the newly elected members of the Maine ENA Board for the 2009 – 2010 term:

- Secretary - Jane Dunstan - MENA Board Member At-Large for the past two years; currently employed at Miles Memorial Hospital as an RNIII; ACLS and TNCC Instructor
- Treasurer - Darlene Glover - MENA Board Member At-Large; Past MENA President; currently the Nurse Director of the ED at Stevens Memorial Hospital
- Board Member At-Large - Carol Grant - Currently employed as a Staff RN at Maine General in Waterville; ENPC and TNCC Instructor

Are you interested in learning more about ENA? Join us at a Board Meeting! All Maine ENA members are welcome to attend. Contact any Board Member for more information.

ENA-SPONSORED COURSES

Thinking about going somewhere warm and sunny this winter? Course dates for all ENA-sponsored courses are listed on the national ENA web site at www.ena.org for the United States and the rest of the world. Make a trip out of it!

Emergency Nurses Pediatric Course "ENPC"

2009 Course Dates – Courses offered at several locations in Maine.

The traditional two-day provider course and the new one-day Re-Verification course are available. Check the Maine ENA web site at www.enamaine.org or contact Carmen Hetherington, RN, BSN, CEN, Pediatric Committee Chairperson, at 795-2874 or hetheric@cmhc.org for details.

Trauma Nursing Core Course "TNCC"

2009 Course Dates – Courses offered at several locations in Maine, dates and locations will be posted soon. Check the Maine ENA web site at www.enamaine.org or contact Geneva Sides, RN, BSN, Trauma Committee Chairperson, at sidesboss@hotmail.com.

"EN CARE"

EN CARE is the injury prevention institute of the Emergency Nurses Association. One eight-hour day is all it takes to be recognized as an ENA Injury Prevention Provider. Anyone can take the EN CARE training course and there is no testing. If you are interested in taking this course, please contact Sarah Scott, RN at sascott19@aol.com.

MAINE ENA WEB SITE

The new and improved Maine ENA web-site at www.enamaine.org is up and running. It contains lots of information, including:

- Membership benefits
- Upcoming events
- "Maine Matters", the newsletter of Maine ENA
- CEN review questions
- Contact information for officers, board members and committee chairs
- And more! Check it out!!!

Have a fun and SAFE autumn season!

Please store firearms and ammunition in separate locked locations and wear a helmet when riding an ATV or snowmobile. Ride safely!

From the I/C News editor…

Greetings all!

Somebody told me some time ago that he understood that a person has to be on the Education Committee to be able to write an article for the Journal of Maine EMS, and that he thought a person had to be on the Exam Committee to write for the I/C News! Let me assure everybody that there are no such requirements. Every contribution is judged on its own merits, and is accepted if the article is appropriate, regardless of what service the author comes from, what region, whether the author serves on any committees, or what level of EMS (or other) education the person has.

If you have ideas for articles relating to EMS education, whether at the licensure level or at the continuing education level, please consider writing for the I/C News. And I think it's safe to suggest that if you have any ideas for articles of a more general EMS nature that would be more appropriate elsewhere in the Journal, you might get in touch with Kelly Rodrick and let her know what you're thinking of writing, and she can help you get started.

Gems from Jan

Jan Brinkman, RN, EMT-P; Maine EMS Education & Training Coordinator

The last several meetings of the Education Committee have been very busy and productive. We are continuing to work on the "Training Standards Manual" which has now developed into the Training Center Approval Process document. The goal of this project is to provide a guide for entities wanting to become Maine EMS approved Training Centers.

Some have asked – why the change?

The answer goes back to the EMSSTAR Report in 2004 that contained recommendations that:

- Maine EMS remove the requirement for regional approval of initial training programs and place this function at the state level.
- Maine EMS develop and implement a process for institutional and agency approval for an ongoing course delivery modeled after contemporary accreditation processes that precludes the requirement for individual course approval.

After the EMSSTAR Report was released, the recommendations were scrutinized and reviewed by several workgroups and the Board of EMS. The above two were placed in the "high priority" category, and the work began.

The goal of the Committee has been to have a process for state approval that follows these recommendations and has the net effect of making quality programs more easily available.

In many ways, the current system will not change that much. We envision the regional offices continuing to offer programs as they have done for decades, and services will still be able to work through their regional offices for courses on an "as needed" basis.

We also anticipate there may be some larger services or other training centers who want to be able to offer courses on an ongoing basis without having to go through a new approval process each time, and that also will become possible.

Over the past four years there have been many discussions on how this should be accomplished, and while we draw closer to having the process designed, it is still very much a work in progress. Only once it is completed will we be able to estimate an effective date, and we will keep you updated along the way.

The Education Committee meets at 9:30 a.m. on the second Wednesday of each month. All are welcome! Please call the Maine EMS office to confirm the date and time of a meeting before coming. If you cannot attend a meeting, but would like to comment on our projects, please feel free to contact Dan Batsie, Education Committee Chair (dbatsie@emcc.edu) or me (jan.brinkman@maine.gov).

Teaching Tips

You can find an article called How to Study for Success in EMS on JEMS.com. It's by Kim McKenna, and is filled with study tips you can share with your students. The article can be found at www.jems.com/news_and_articles/columns/McKenna/Studying_for_Success_in_EMS.html. There's a follow-up article called How to Prepare for the Big One at www.jems.com/news_and_articles/columns/McKenna/Preparing_for_the_Big_One.html.

Item Response Theory Tutorial

In a May 2008 e-mail communiqué, the National Registry suggests readers go to www.creative-wisdom.com/multimedia/IRTTHA.htm to view an online tutorial about Item Response Theory. Maine's instructors might find this information helpful in understanding computer-based testing.

Proper Processing of CE Paperwork

By Kelly Rodrick, from the September/October issue of the KVEMS Pulse

We have noticed an increase in problems surrounding continuing education programs around the state so I wanted to take this opportunity to review the process for applying for CEU's as well as turning in the roster after the program.

1. Applying for CEU's – According to Maine EMS Rules, a request form must be received in the regional office prior to the start of the program. Technically, under the rules, requests that are received after the start of the program should go to the MEMS Board for a waiver. We are willing to work with individuals to make sure that attendees received appropriate credit, but if we routinely receive late requests from the same person, we may refer that individual to Maine EMS for consideration of loss of CEU request privileges.

   The request must submitted on the approved request form and be accompanied by an outline of the program. Make sure your outline has sufficient detail to support your hours request, both the total and category breakdown.

2. Attendance Roster – The roster must be returned to the regional office that approved the program within seven days of the completion of the program. This is one of the areas that we are experiencing the biggest problems. Students who attend the program have a right to expect that the roster will be returned and forwarded to Maine EMS in a timely fashion. The instructor should review the roster prior to sending it to the Regional Office to make sure it is complete and legible. Maine EMS has requested that we send them the original roster, so please make sure you send the original to the Regional Office.

3. Evaluations/Certificates – Evaluations should be completed by the student and sent in to the Regional Office with the roster. Course sponsors/instructors are responsible for providing a certificate for each attendee. Certificate templates are available from the Regional Office.

[Ed. note: The above reflects the preferences of KVEMS. Other regions may have slightly different requirements, and if you have any questions, you should contact your regional office directly.]

Committee Briefs

Exam Committee

By Jacky Vaniotis, RN, NREMT-P, Chair, MEMS Exam Committee

The Exam Committee continues to work on revisions to the current Exam Administrators Manual. Once that work is complete, and the revised manual is approved by the Board, it will be uploaded to the MEMS web site. We anticipate that happening in early 2009.

In order to tighten up the process for Integrated Practical Exams, the committee has enhanced the timeline for contacts between the State Evaluator and the course instructor/coordinator. The enhancement includes two additions. First, within three days of receiving the IPE confirmation from MEMS, the State Evaluator will contact the I/C to confirm the date, time, and place of the IPE. Second, he or she will call the I/C again one to two weeks before the scheduled IPE to reconfirm the date and time, review expectations, ensure that the I/C has the necessary facility, examiners, programmed patients and paperwork, and answer any questions the I/C may have. The State Evaluator will, as previously, contact the I/C on the day of the IPE, at least two hours prior to its scheduled start, to discuss any last-minute issues. The I/C will have access to emergency contacts in the event that he or she does not hear from a State Evaluator two hours before the exam. That allows MEMS to arrange to get an alternate State Evaluator to the site if necessary, so the exam can proceed as planned.

At its October meeting, the committee also began a review of the Intermediate exam, which is the only written exam that Maine EMS continues to administer now that all other levels' licensure exams are done through the National Registry.

Please feel free to attend any meeting of the Exam Committee, which meets on the fourth Tuesday of each month at 9:30 a.m. As always, we recommend that you contact the MEMS office before coming to make sure a meeting has not been canceled or rescheduled.




Photos by Cathy Case and N. Reynolds

Mike's Training Moments

By Michael James Azevedo, Jr. EMT B; Chief, Carmel Fire & Rescue

I offer greetings to all EMS providers in the great State of Maine. Pediatrics is the choice of topics for this issue of the Journal of Maine EMS. You are probably praying, as I do, that when a child gets hurt, either you are not on duty or the other crew gets the call. This prayer has worked well with me for 18 years, but several times during my career I have drawn the short straw.

Pediatrics can be a challenge. As a father of two boys and one girl, who has actively participated in raising them from infancy, I do not look forward to dealing with children when they get injured. Whenever any of my children have been injured, I do not call 911 for the ambulance, but usually call their mother at work. She gives me the standard answer, "Why are you calling me, you are the EMT." So last time I hung up the phone and called our doctor's office. I have had to learn the hard way how to stop bleeding, apply bandages, stop the crying, get ice, and still clean up the house afterward.

The only way to become comfortable with children is to spend time with them. I must admit I would not touch a baby until my wife and I had ours. After that, I realized that children will not break when they are picked up. If you do not have children of your own, spend some time working with Cub Scouts, the church, or volunteer at the local school. The schools are always looking for someone to read to the little kids. Interacting with children will quickly show that they are very different from adults. (Please note that you may have to take a training course under FERPA, the Family Educational Rights and Privacy Act, if you want to volunteer at a school. The Boy Scouts of America requires a class called Youth Protection, which can be taken online, prior to working with scouts.)

All training exercises need to be practical, realistic and interesting, and this includes pediatric training exercises. Check with your squad members to see which ones have children who would be willing to participate. My children like riding in the fire trucks, so we have a trade off: if they let me practice on them, I let them ride in the fire trucks. Over the years, I have practiced blood pressures and pulse checks on my kids. My oldest son has a heart murmur that can be heard across the room. Lung sounds can be interesting when the kids have colds. I am not as good as their mother, but I can generally tell when children are sick by looking at their eyes. Also the fact that they stop running around and want to sit with mom is another indication.

Here is a potential outline and some other ideas you can use when trying to teach pediatrics to your rescue squad:

1) Review the American Heart Association age guidelines for infants and children.
2) Review CPR standards for infants and children.
3) Review appropriate vital signs for children of different ages.
4) Review Maine EMS protocols for infants and children.
    a) This is the pink section.
    b) Review ALS protocols if you have EMT-Is and EMT-Ps.
5) Review some of the issues facing children today. These issues can be researched by looking online. Below are a few ideas:
    a) ADD
    b) ADHD
    c) Autism
    d) Cerebral Palsy
    e) Epilepsy
    f) Emotional, physical, and sexual abuse
    i) Review Maine EMS policy, including when to call the Department of Health and Human Services (pages 12 and 13 in the grey section of the protocol book).
6) Know the location of the pediatric equipment.
    a) This is where I have the most difficulty.
    b) Know how to use all the pediatric equipment you have.
7) Check to make sure your equipment is in good working order.
    a) We do not use it enough.
    b) It gets outdated.
    c) It gets abused bouncing around the truck.
8) For one class you might ask a school nurse, a nurse who teaches children, or one who works on the pediatric floor at the local hospital to come speak to your ambulance or rescue service.
    a) They know more than I ever will.
    b) They deal with children on a daily basis.
    c) And if they have a sense of humor, you are golden.
9) For another class you might invite a guidance counselor or a person who works with troubled children to come speak to the group. In my scout troop I have a child who reacts to loud noises, and he will shy away from the noise. Raising my voice is detrimental to our conversation. I have learned how to communicate with him over the past sev-

eral years. A guidance counselor might be able to provide insight into dealing with children with problems like this.

10) A complete review of obstetrics and delivering children would be a good evening review.
    a) This would be a good field trip to the local hospital.
    b) Nurses and doctors may be willing to teach this for you.
    i) How about a midwife???
11) Check with the EMS office for pediatric training supplies if you do not already have them.
    a) Please note: I prefer to use our own equipment.
12) This is a good chance to look at next year's budget and start purchasing more up to date pediatric supplies. There are different car seats, back boards and other gadgets you can use. Speak to sales representatives at conferences to get ideas, or look in medical supply catalogues.
13) Label your equipment so you can easily tell the difference between adult and pediatric supplies.
    a) I find that plastic sandwich bags with construction paper in them make it easier to tell pediatric from adult equipment. This works really well on oxygen masks: blue paper for children, pink paper for infants.
14) A school size backpack makes an inexpensive pediatric trauma bag.

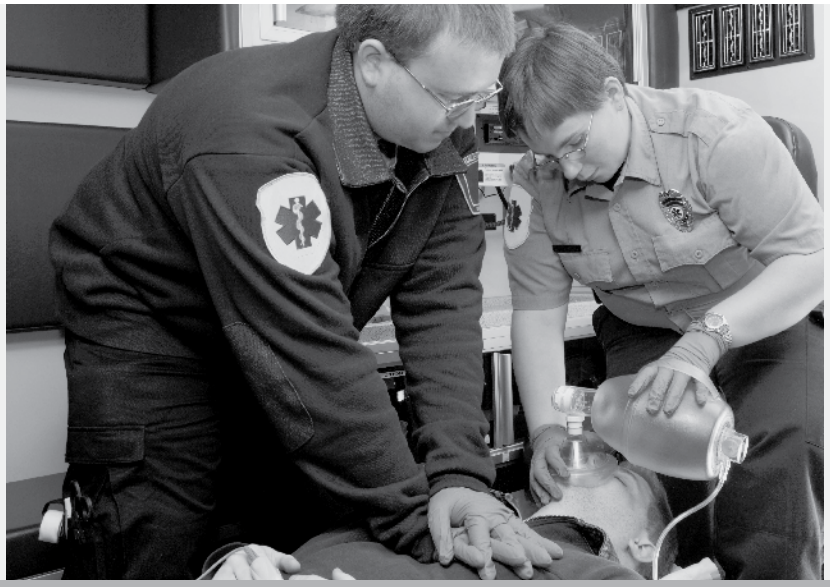
An example of a practical station would be to extricate a child from the back seat of a car. Place a collar on the child, and remove him or her to a backboard. Complete an assessment. Take a complete set of vital signs. Move the child to the ambulance. Remember to talk to the child and the parents so they both know what is going on. Don't forget about the parents or siblings, especially if they are in the automobile.

Lastly, I would like to mention a former ambulance member in my town, Elaine Hill. Elaine likes to make quilts. She makes them yearly so that if we have a pediatric ambulance call, we can leave a quilt with the patient. I find that sometimes these work better than stuffed animals. If you have a member who likes to sew, this can be a neat advertising tool for the squad, too.

If you have stuffed animals, make sure they are in a sealed bag so they stay clean. If your stuffed animals are in a compartment and they get covered with dust and you give them to a child with asthma, you may cause further issues. Also what germs are you giving to the child? Seal the stuffed animals in large plastic bags or use freezer-type sealable bags.

And remember that every child you treat is a future potential squad member.

Until next time, THANK YOU for the people you train and the lives that are saved as a result.



Please submit any materials you would like to have published in the next issue of the I/C News by February 13, 2009 for publication in the April 2009 edition of the Journal of Maine EMS. Submit material to: Jacky Vaniotis, 172 Haskell Road, North Yarmouth, ME 04097, or email JackyV@Vaniotis.com

30 Students Injured in a Bus Crash

Mass Casualty Exercise at Eastern Maine Medical Center

By Jeremy Damren

Radio Traffic"This is Bangor Fire Department to Eastern Maine Medical Center. We are on scene with a school bus roll over involving approximately 30 elementary students, ranging from 5-11 years of age. It's believed that the brakes failed while traveling down the steep decline leading to the intersection of Veazie Road, State Street, and Hogan Road. The driver reported that he attempted to navigate a last minute turn at a high rate of speed, but lost control. The bus rolled over at least 3 times before landing on its side. The rear end of the bus is partially submerged in the river. Several children appear to be trapped in the submerged section of the vehicle. Several other victims have been lying in the diesel fuel."

As EMS providers receiving a call to respond to this scene would probably seem like just a bad dream. Just hearing the call being dispatched would certainly make me wonder why I had chosen to be an EMS provider. 30 children, possibly your own, involved in a bus conjures up images of serious trauma. The bus is partially submerged in the river and some children are in the water. Some of the other children are lying in the diesel fuel leaking from the bus.

As responders, it is "second nature" to assess a chaotic situation and develop an effective triage system to rescue the victims quickly and safely.

We know what we would do, or should I say what we are supposed to do in a mass casualty incident such as this. We have practiced full scale exercises with an active shooter scenario, hazardous materials exposure with evacuation, explosions with several fatalities and injuries, and the list goes on. As responders, we practice what we do. But, do we ever stop to think about what hospital staff is doing?

After the hospital staff receives the radio call, how do they prepare for our arrival? Do they activate their own Incident Command System (ICS)? As EMS responders, do we consider the impact of 30 patients arriving back to back at Eastern Maine Medical Center?

I was able to participate and observe in a functional exercise that took place on September 19, 2008 at Eastern Maine Medical Center. At 0730hrs, they received a call of this nature and were expected to activate their incident command. I was quite impressed and it was certainly very interesting to see what a large hospital does to prepare of this type of incident.

The first step after receiving this call from Bangor Fire was to assess the situation in the emergency room; case typing to identify those who could be safely moved out of the emergency room. Total, they had 39 patients to be seen ranging from respiratory problems to coughs and colds. Some of the 39 were serious and others were not. The types of patients were broken down to what their problems were. Therefore, they could move the patients out of the ER who were not imminently ill.

After paging over head and through their specific communications system, all assigned individuals reported to EMMC's Emergency Operations Center (EOC). They quickly set up a command post and assigned an Incident Commander, Security Officer, Liaison Officer, Planning Chief, Logistics Chief, Finance Chief, and an Operations Chief. The specific duties of each job are outlined below:

As EMS providers, receiving a call to respond to this scene would probably seem like just a bad dream. Just hearing the call being dispatched would certainly make me wonder why I had chosen to be an EMS provider.

Incident Commander (IC): The IC was in charge of the overall management of the incident.

Public Information Officer (PIO): The PIO was in charge of information releases to the media. The media is an excellent avenue for disseminating information; the PIO needs to tell the story.

Security: Safety and security of the organization, staff, patients, visitors, and facility.

Liaison: Coordinating with all outside agencies such as the appropriate schools involved, the local businesses calling in, and anyone that needs a connection with the hospital.

Planning: Responsible for the tracking of patients, beds, personnel, and materials throughout the hospital.

Logistics: Responsible for communications, employee health and well being, family care, supplies, internal/external transportation, and acquiring and credentialing additional personnel.

Finance: Responsible for tracking costs of response and recovery and payment of invoices.

Operations: Responsible for staging of personnel, equipment, vehicles, and medications. Medical care, infrastructure to include electrical power, food services, any damages, and security to include crown control, and decontamination of all.

Each of these tasks were assigned accordingly as people came to the EOC in response to the page. They each sat at a designated table which was clearly

labeled as to what section they were. Each chief wore a vest to clearly identify who they were.

Decontamination procedures were put in place immediately due to the report that some of the children were lying in diesel fuel.

Updates were conducted every 15 minutes or so. The incident commander announced by microphone what the updates were and any additional tasks that needed to be completed. Kathy Knight, RN, Director of the Northeastern Maine Regional Resource Center designed the exercise and submitted the injects.

At 8:15, ambulances had transported 6 multiple trauma victims. Family members requested clergy for one of the victims. At the same time, the hospital received a call from an anxious parent demanding to know where their son is. The parent stated that the Emergency Department denied that his son has been admitted following the accident. The caller is spouted profanity and threatened bodily harm if someone didn't find his kid.

While this was going on, the community relations section/Liaison received a fax from the local elementary school which listed all of the school children who should have been on the bus. There should have been 35 but only 30 were reported.

Questions to consider:

- How are these children going to be identified?
- Do any elementary children carry photo identification?
- In the EMS field, we try to identify the injured but if we are unable to, let the hospital deal with it.

At 8:30, it became very chaotic in the hospital. Not only were news crews arriving and requesting information, but family members and visitors for the victims of the crash start to arrive. Anxious parents left their vehicles in front of the entrance, blocking other cars from entering or leaving.

Questions to consider:

- Who deals with all of the angry/distraught/curious parents?

At 8:50, someone entered the EOC and started to yell, "Where is my son?" The EOC quieted down to a whisper as everyone looks at the angry father. Someone immediately took the parent outside. This incident gives a sense or realism to the hospital staff. After he was escorted out, the staff went back to work as if nothing had ever happened.

More injured and deceased children continue to arrive. Constant reports are being given as to the bed status, transportation of victims to other hospitals, and to the emergency declaration allowing doctors from other hospitals to come into EMMC to practice there.

The staff decided to open up a family center where family members may gather upon arrival and quickly developed a family support team to deal with the considerable emotional toll.

Within time, all victims were transported to the emergency room. The transport team, under the Logistics Chief decided to fly some of the victims to other hospitals, quickly treat and admit other victims, and cleared the operating room schedule to allow the more imminent victims to receive the care they needed.

This exercise ran smoothly. Despite 30 victims being transported in under 3 hours, angry parents showing up in the EOC, cars blocking the parking lot, and many other problems, everyone worked their assigned job as if it was a real event. I even commented to Kathy Knight how the Incident Commander had no problem ordering everyone to keep the room quiet and continue the process.

If this really happened, would a hospital as large as Eastern Maine Medical Center be able to handle it? Some may argue that none of the hospitals in Maine would be able to handle the emergency. One thing is for sure. This exercise positively reflects what the EMMC staff is capable of and will help them be better prepared in a real event. Exercise and training is a vital tool for public health and emergency response personnel. A table top can lead to further training and eventually other exercise opportunities. I encourage you to talk about the "what if" situation that may arise; these may be valuable to include in your department's training. I encourage everyone to get involved in mass casualty incident training and exercises.

Great job Eastern Maine Medical Center!

Jeremy Damren is the State Exercise Coordinator for Maine Emergency Management Agency. He is also a paramedic for Delta Ambulance and a member of Belgrade Fire/Rescue. He teaches ALS & BLS Licensure Courses for KVEMS/KVCC.

What's A Crowd?

(In Your Ambulance, Helicopter or ED)

As an EMT and instructor in the '70's and '80's, with EMS for Children…"EMS-C"… training in the '90's, I recall the sum total of my preparation for interacting with those on scene when called for kid emergencies:

- Instill confidence (act like you know what you are doing even if you don't; and suppress the abject terror you feel in a "bad" one);
- Be calm;
- Ask the parents what they are worried about (if not obvious) and how the child is acting differently than usual;
- Be calm;
- Try to achieve eye-level interaction when addressing the child;
- Be calm;
- Do not lie to the child (unless very ill, they'll be on to you in a flash);
- Be calm;
- If possible, particularly in a dicey respiratory situation like possible epiglottis, let a parent cradle the child into the hospital (secured, on the cot);
- Be calm;
- Let the parent ride with you in the back unless you need, or may need, the room to work and can't do so safely;
- Be calm;
- Children are not little adults (interact, treat, medicate, and the like, accordingly);
- Be calm (dammit)!

My practice has pretty much reflected these principles, yet a meeting in 2000 in DC, intimated…no, screamed at me…. that I might not be doing all that I could.

Enter "Family-Centered Care or Patient and Family-Centered" (FCC, PFCC). What is it?

"Family-centered care is a systematic approach to building collaborative relationships between health care professionals and families that uses those relationships to assist in providing quality EMS care… It acknowledges and uses the family's knowledge of their family member's condition and their skills in communicating with and caring for their family member. It emphasizes the importance of keeping family members informed about their loved one's condition, prognosis, and treatment. Family-centered care encourages family presence during procedures. Family-centered Prehospital Care embraces family-centered care principles during on-scene treatment, transport, and transition of care to in-hospital health care providers."[1]

Okay, so sounds like I'd been doing it (just didn't know it had a name). So, what led me to believe otherwise?

At that meeting, we heard from family members for whom interactions between their children and EMS had ranged from wonderful to disastrous.

On the wonderful side were those whose kids' outcomes were good in the face of a life-threatening circumstance and who had been allowed to participate in all aspects of care from scene into ambulance patient compartment and into ER treatment room.

On the disastrous side were those whose child died after being taken from their presence by tense acting EMS personnel and sequestered on the scene, in the ambulance, and in the ER, until a physician came out with the grim news.

In between, but decidedly positive among those presenting, were parents whose child had died but who had been allowed to participate in the process, accompanying their child throughout, giving history and observations, and being able to see, touch, and comfort the child as possible. It must be emphasized that, despite the introduction of the family-centered care notion in general in the late 1980's, we were presented primarily with anecdotal encouragement of this sort, and came away with little evidence basis.

The top three recommendations of that meeting were:

- The safety of all team members, including family members, must remain a primary concern during prehospital care and transportation.
- Family representatives or organizations should be involved in primary training for prehospital emergency medical responders at all levels.
- Family members should be given the option to be present and to participate in prehospital care on scene, during transport, and during transfer of care to the receiving facility.[2]

I have had my share of pediatric codes and life-threatened kids in 32 years of practice, and I have to admit that I can only remember a few times having invited the parent to ride along (some of those dicey respiratory cases, and one conscious, scared, 11 year old, trauma patient for whom it was just "right" for everybody). Most of the time, I would invite a parent into the front of the rig with the driver, or to come separately (if there was someone sufficiently together to drive and who promised not to follow on our tails or worry if we stopped to do something….right).

I brought this revelation of sorts reporting back to the National Association of State EMS Officials that I represented at the DC meeting, and to

Maine where I just wanted to compare reaction with my own, and shared it with state EMS directors and with my colleagues in the field and ERs around the state. I can't say that I stirred much excitement in any corner. Mostly people thought it sounded well-intentioned but impractical (putting it politely).

Why the hesitation? Beyond the safety issues, one study revealed why some ED staff demure from the idea:

"Potential healthcare provider concerns about family presence relate to perceptions of increased litigation, increased stress during resuscitation, distraction by hysterical family members, family member interference, and decreased effectiveness of team members…Concerns about the traumatic effects of observing resuscitation have also been raised."[3]

Hidden behind those references to "increased stress" and "decreased effectiveness" I can certainly imagine are questions of confidence during procedures (our having done few major kid procedures in general, with a parental audience in particular), general tension about kid calls and wanting to maintain a bold front for parents' sake, and issues of open discussion among staff during decision-making moments (especially if that is to end an unsuccessful code).

Studies have underscored a parental desire to be involved in emergency and other procedures, while they demonstrate a mixed reaction to the concept among emergency providers.[4, 5] While these studies are ED-focused, there is no reason to believe that they don't apply in the pre-hospital setting. Early on, the American Heart Association, Emergency Nurses Association, American College of Emergency Physicians, and American Academy of Pediatrics recommended family presence during CPR procedures where possible.[6,7,8]

Eight years after that DC meeting, I realized that I had lost track of the family-centered care concept. It certainly hadn't burned up the waterfront in Maine that I could see, nor was much of a feature in the mail traffic and literature across my desk on the national level. So, I decided to check in with those who might have a better clue.

First, I decided to do a quick and dirty of the literature. There are many related articles circulating in the past few years (a few more easily accessed are listed as "related reading" below). Interestingly, a 2008 article says that, still, "Well-designed research that establishes the effects of a PFCC approach to care of the child in the ED is limited."[9]

Additionally, it appears that prehospital research and literature is even more so.[10]

Next, I contacted those on the state and national levels who are experts in the field. The Maine EMS coordinator for all things EMS-C (though admittedly new at it), as well as the state training coordinator, Jan Brinkman, acknowledges that FCC (to the extent of widespread family involvement in code and other major procedures) has not yet penetrated EMS in either the prehospital or hospital settings.

She says, however, that the concept remains core to EMS-C and that a new training program, SCOPE, may well help to spread provider appreciation for family involvement in emergency care. The SCOPE program focuses on special needs patients and the greatly helpful roles of family members in dealing with emergencies. It is expected to be a one day course, with train-the trainer classes in 2009 and provider classes beginning in 2010. "We really need to work with family, not over or around them. It can make for faster on-scene care and more appropriate outcomes" she said.

Kelly Roderick, chair of the Maine EMS committee on EMS-C has worked nationally and locally with families who have had children/EMS encounters. She has heard it all:

"They don't listen to me. I know what is normal for my kid."

"They just act scared and try to get my kid in the ambulance away from us".

"Before I call EMS again, I'll just put my kid in the car and go to the ER".

> *First, take your own pulse! Then listen to the parents. Ninety per cent of the diagnosis is the history, and you will have more critical clues from that than from your physical exam. Then launch into your ABC's*
>
> *Dr. Joe Wright*
> *Medical Director of National EMS-C Resource Center*

She says that these family members want the EMS system to work but, in some cases, have lost confidence in it. She says that the lack of penetration of FFC in the system is because the second goal of that 2000 conference cited above (getting families involved in primary EMS training and FFC into the curricula at all levels) hasn't really happened.

In an interview for this article, Dr. Joe Wright, the Medical Director of the National EMS-C Resource Center in DC, and an emergency pediatrics specialist, acknowledges the lack of FFC research, and penetration in EMS, particularly in the prehospital setting (see also reference 10). He is heading up new research with federal funding to look at FFC in the trauma care setting, and hopes to establish better evidence –base for the appropriate FFC practices. He states the quandary:

"The literature is really ED-based, and it hasn't been overwhelmingly convincing for hospital practitioners, though many tools and guidelines for hospital emergency practice have emerged, and there seems strong consensus to move in this direction. There is always the question of how much we can really back out of the ED literature and apply in the prehospital. How much can we really do in the confines of the ambulance or helicopter?"

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Dr. Wright is a strong believer in "family presence" and believes that FCC, for EMS purposes, has largely "coned down" to that focus.

His advice to EMS providers (and he still reminds himself of this after working more than 20 years in emergency settings with kids): "First, take your own pulse! Then listen to the parents. Ninety per cent of the diagnosis is the history, and you will have more critical clues from that than from your physical exam. Then launch into your ABC's".

He echoes some existing literature with a fine suggestion. "In the ED, we have tried to establish an intermediary, 'interpreter' role to act as a go-between those trying to perform care and the family. They get information requests from the hands-on providers and turn to the family members present, or in the next room, and provide explanations of procedures, their progress, and the patient's overall progress as care goes on".

Dr. Wright and Ms. Brinkman especially encourage this interaction when kids with special needs have medical equipment or procedures used on a chronic basis. Brinkman notes "You aren't expected to be the expert in all of those things. Rely on the family to know how to clear a trach or work a machine."

Dr. Wright suggests that a such an interpreter role would benefit all in many prehospital settings, perhaps more on the scene than in a cramped vehicle (but that consideration should be made too; in the patient compartment or between front and back). On a pediatric call, where the primary provider(s) expect to be very busy, using a first responder agency member, an extra squad member, or calling in back-up to serve in the interpreter role should be considered.

In its 2006 report Emergency Care for Children: Growing Pains, the Institute of Medicine (IOM) concluded that failure to incorporate PFCC and culturally effective care into emergency care practice "can result in multiple adverse consequences, including difficulties with informed consent, miscommunication, inadequate understanding of diagnoses and treatment by families, dissatisfaction with care, preventable morbidity and mortality, unnecessary child abuse evaluations, lower quality care, clinician bias, and ethnic disparities in prescriptions, analgesia, test ordering, and diagnostic evaluation." [11]

Yikes, how do they really feel?

I don't question that FFC or family presence is in our future. To some extent, I think it is in our collective EMS blood already, and we know that it is the right way to go.

Fortunately, we don't get many serious kid calls. Unfortunately, that means that no serious call scares us like a kid call. Our job is to appear confident even when we aren't (be calm), so as to instill confidence in our abilities in those around us. Asking people at the scene for help or advice runs contrary to our view of ourselves as "all capable, all confident". We can't do much about the number of pediatric calls we get or, therefore our level of experience. But if we can accept that part of our ability is to ask for help and information when we need it, in a confident manner, then maybe FFC won't be such a deal. We ask for lots of other bystander help, don't we?

It is clear that we need to take every opportunity to learn more, watch the research and make FFC a topic of open conversation and policy-making in our institutions and prehospital services.

Kevin was the director of Maine EMS from 1986-1996, is a member of Winthrop Ambulance Service and currently works for the National Association of State EMS Officials as a program advisor. He also serves Maine EMS as a part-time trauma system manager.

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2- Guidelines for Providing Family-Centered Prehospital Care; (proceedings of the consensus meeting on family-centered care, July, 2000, Washington, DC). National Association of EMTs and Maternal and Child Health Bureau, Emergency Medical Services for Children program, Health Resources & Services Administration, U.S. Department of Health & Human Services.

3- Eppich WJ, Arnold LD; Family member presence in the pediatric emergency department; Current Opinion in Pediatrics 15:294–298; Emergency and Critical Care Pediatrics, Lippincott Williams & Wilkins; 2003

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5- Knapp J, Mulligan-Smith, Committee on Pediatric Emergency Medicine, American Academy of Pediatrics; Death of a child in the emergency department; Pediatrics;. 115: 5: 1432-1433; August, 2008. Accessed 11/08: http://pediatrics.aappublications.org/cgi/content/full/115/5/1432

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7- American Heart Association. Guidelines 2000 for cardiopulmonary resuscitation and emergency cardiovascular care. Part 2: ethical aspects of CPR and ECC. Circulation. 2000;102(8 suppl) :i1 –i21

8- Gausche-Hill MA, Fuchs S, Yamamoto L, eds. APLS: The Pediatric Emergency Medicine Resource. 4th ed. Sudbury MA: Jones and Bartlett; 2003

9- O'Malley PJ, Brown K, Krug SE, Committee on Pediatric Emergency Medicine, American Academy of Pediatrics; Patient- and family-centered care of children in the emergency department; Pediatrics; 122(2): e511 - e521; August, 2008. Accessed 11/08: http://pediatrics.aappublications.org/cgi/content/full/122/2/e511

10- Guzzetta CE, Clark AP, Wright JL; Family presence in emergency medical services for children; Clin Ped Emerg Med 7:15-24; Elsevier Inc; 2006.

11- Institute of Medicine. Emergency Care for Children: Growing Pains. Future of Emergency Care Series. Washington, DC: National Academies Press; 2006 Read this book on-line free at http://books.nap.edu/catalog.php?record_id=11655

Related Reading

Due to limited space for listing a reading list, I recommend that the reader access the already-cited article below. Its online version has 34 citations which are easily accessed on-line and represents a most up-to-date reading list:

Knapp J, Mulligan-Smith, Committee on Pediatric Emergency Medicine, American Academy of Pediatrics; Death of a child in the emergency department; Pediatrics;. 115: 5: 1432-1433. Accessed 11/08: http://pediatrics.aappublications.org/cgi/content/full/115/5/1432

THE RESIDENTS CORNER

TRIPP CARTER, MD
PORTSMOUTH REGIONAL HOSPITAL

Conferences:

Sugarloaf 27th annual winter symposium

Sugarloaf Inn, Kingfield, ME, March 3-6, 2009

FMI: Email Beverly Maclean @ macleb@mmc.org

DEAPA winter conference

January 28-31, 2009, Bethel Inn, Bethel, ME

FMI see: http://www.deapa.com/deapawintconf.php

Musings:

Running with scissors….

Trekking through North-Central Nepal this October, I was torn between gazing at the incredible scenery and trying to save my ankle on the next mule-drop laden slate stair. The dilemma was usually resolved by stopping and taking yet another picture of golden terraced fields fronting 20,000 + foot, snow-corniced peaks. It all seemed surreal: men plowing fields with oxen and wooden plows, hollowed logs directing water into grist mills grinding corn, bamboo thatched roofs on stone houses. I kept looking for the Disney-world workers hiding behind the next conical haystack of harvested rice-straw, but they were either very discrete or this was indeed the real thing.

There is, however, a darker backstage to this idyllic setting. In Nepal the under-5 mortality rate is about 75 deaths per 1000 live births while in the US (middle of the pack in developed countries) it is 7 deaths per 1000. (WHO statistics …2006). About ½ of this high rate is attributable to neonatal tragedies, twice as high in this rural part of Nepal as in its cities only 150 miles distant. Most of the rest of the deaths are a result of infectious diseases with only 2% of the total secondary to accidents. I found this latter statistic puzzling since the 1 ½ hour coach ride to the trailhead rivaled any amusement park experience in the States. Nepalis drive on the left, actually only a suggestion. Any lane is a passing lane and the speed limit is determined by how fast you can get your vehicle to go. As for fitting two full size buses, several oxen, a group of schoolchildren and a stalled tuk-tuk (kind of a 3-wheeled taxi), all in the same two lanes at the same time on a cliff-clinging road, this could only otherwise be done in Harry Potter's Knight bus.

Curiously with all the safety requirements we have, accidents are the leading cause of death in the under-5 age group in the US outside the neonatal period. This does not mean that Nepali roads are safer. They aren't. The highway fatality rate is 61/10,000 vehicles in Nepal and 1.7/ 10,000 vehicles in the US. It's just that there are overall not that many vehicles or indeed roads they could be driven on in Nepal. Folks don't wear seatbelts in Nepal except sometimes-in front seats. There a lot of motorcycles in the cities and the drivers usually wear a helmet, but the 2 kids in the front of the driver and the one in the back in front of the goat don't. Everyone drives by his or her horn, but nobody gets upset about this especially pedestrians: now they know when to get out of the way.

Since much of Nepal is rural, there are plenty of other ways for kids to get hurt besides playing in traffic. Northern Nepal is quite mountainous. Along our trek we camped in fields near the small towns. There were several times when the front of the tent was only 6 feet from a 30-foot drop-off. I did not see the guardrails, high fences, flashing warning lights, motion detectors and signs in 10 languages warning me that death or worse were imminent if I were to test gravity by going farther than solid ground allowed. There was also no pile of small children at the bottom of this minor cliff in spite of many inquisitive little guys and girls always hanging around for a "sweet". I saw five year olds with sharp steel sickles going out to help in the fields, 3 year olds clinging to 12 foot grassy embankments wrestling with their siblings, 6 year olds playing with fire in crowded streets at night, kids playing in the woods a mile from their villages after having forded raging streams and dirt-strewn paths overlooking 200 foot drops to the river below, kids…. well you get the idea.

So is this a rant about too many safeguards on kids today? No! While we can go overboard perhaps with implantable GPS chips in our children, many of the safety items developed from child proof caps to window guards in New York City have proved to be life saving. However, certain safety regulations may not translate to other environments where they either may not be as useful or simply add cost to health care that could be used in more effective approaches. One example from our trek was that of clean drinking water. Some of the trekking companies decided that carrying bottled water to last the whole trip would make clients both feel and be more confident in what they were drinking. One of the unanticipated side effects was the volume of discarded plastic bottles in each village all along the way. The villagers had no use for these discards and there was no way to recycle them in the mountains. They are now banned at the highest reaches of the trek and the old way of boiling and/or iodine has returned. I would make a plea that whenever a recommendation is made, it should be well researched, tried on a representative sample and evaluated for its effectiveness. Don't expect that what may work in one culture will work in another. One of the joys of travel for me is seeing people living happily through ways that are completely different from my own.

Namaste!

Another Life Changing Experience

Holly Buschhorn, MD, Chief Resident
Maine Medical Center Emergency Medicine

Every once in a while we as medical providers are faced with a particularly difficult case, and the experience that results teaches us a lot about both medicine and ourselves. These are cases you think about for days, weeks, months, and forever, wondering if a slightly different scenario had occurred, if you had done something more, something less, or something else, a different outcome would have resulted. As I have advanced through my medical training, I have had many of these situations, but I recently had one of those experiences involving a pediatric patient that still captures my daily thoughts.

It was the beginning of my pediatric ICU rotation when a call came in about a critically ill patient intubated after respiratory failure from status asthmaticus. The patient had presented to the ED earlier that day and did not respond to the usual aggressive management for asthma. The clinical course evolved over the day in that it appeared this event was precipitated by severe pneumonia. The patient was at an outlying hospital and needed transport to Maine Medical Center's PICU. The decision was made to transfer via ground transport, so the Pediatric Transport Team, which I was now a part of, was activated.

"Pedi Transport" is a service provided out of the pediatric critical care department at MMC. The "Angel" ambulance as it is called, is called to service multiple times a week to transfer critically ill patients from smaller outlying hospitals without PICUs to MMC. The medical personnel that comprises the team make it a portable extension of PICU care. A pediatric or emergency resident physician, a respiratory therapist, a PICU RN, and a paramedic comprise the team, and the critical care attending oversees the care via frequent phone contact.

This was my first transport, so another resident joined me for my orientation. We were accompanied in the ambulance by the usual transport team. When we arrived to the facility, the patient was as billed, sick. After a prolonged transfer of care and restabilization, we were finally ready for transport back to MMC. Everyone in the back of the rig was on edge, which was spot-on given the events that were about to unfold.

I finally understood how it is to work with the resources available in the pre-hospital setting, while trying to take care of a patient actively trying to die on you. Thank you for what you do.

About 20 minutes out, the patient still had high peak pressures but was maintaining oxygenation well on the ventilator and didn't demonstrate any tension pneumothorax physiology. The patient was hypertensive and tachycardic when we left the outlying hospital, and this continued throughout transport, though the heart rate was slowly but steadily increasing…as was mine. While the resident with me reevaluated the patient, he suddenly got this concerned look. "Did the pupil look like this before we left?" The nurse and I looked, and watched as the right pupil continued to slowly dilate, while the left remained unchanged. We checked, it was not reactive. The patient was herniating right in front of us, and I felt helpless.

Why is this asthmatic with pneumonia herniating? The patient was paralyzed with vecuronium, could that have affected the pupils in any way? (No.) Did we miss anisocoria prior to leaving? (No, and why would it be non-reactive.) What was happening? And then we looked from the patient's face to the rhythm strip, which continued to have sinus tachycardia, but the morphology was different. Again, what was happening, maybe this was neuro related? (Not primarily.) We ended up raising the head of the bed and giving furosemide to reduce increased intracranial pressure. We decided against hyperventilating given the already tenuous respiratory status. Those last few minutes to the hospital felt like an eternity. We were utilizing all the resources we had available, but could do nothing more until we arrived at MMC.

I am used to working in an ED, surrounded by attendings, other residents, nurses, and techs. When we have a critically ill patient arrive to our ED, we often have too many hands and minds trying to help. I'm sure you witness this every time you bring a patient to us at MMC. Because of the help we have, we're able to quickly care for patients, performing diagnostic and therapeutic procedures in parallel rather than series. While sitting in the back of the rig, waiting to arrive to what I knew would be a lot of help, I felt so isolated. We had the personnel present in the ambulance to take care of whatever wild card

Remembering Each Sacrifice Honoring Each Contribution

More than $20,000 have already been raised for the Maine EMS Memorial planned to be constructed next to the fire and law enforcement memorials next to the capitol on State Street in Augusta, but more donations are needed to meet the $300,000 goal.

For more information on how to donate, visit www.kvems.org.

the patient threw at us next, but I can now empathize with all pre-hospital care providers the feeling of relief when you are caring for a critically ill patient, and finally arrive in the ED.

In my residency training, I had already developed the utmost respect for pre-hospital care providers, but this experience sent me to a new level. I finally understood how it is to work with the resources available in the pre-hospital setting, while trying to take care of a patient actively trying to die on you. Thank you for what you do.

When we arrived to MMC, the rig doors literally exploded open and we had the patient in the trauma room in no time. In hindsight, it probably would have been amusing to see how fast we were moving; I know I couldn't wait to get out of the back of the truck! Shortly after transferring to the trauma stretcher, the patient went into polymorphic VT, and a long and challenging code ensued. With the ED team working alongside the PICU team, we ran through the ACLS algorithms multiple times. The patient arrested multiple times yet responded to defibrillation, code drugs, and bilateral chest needle decompression. At one point midway through the code, I had the ultrasound probe on the patient's chest while we were assessing for spontaneous pulse, and we could see blood pooling in a non-contractile heart.

We eventually stabilized the patient, and were able to get a CT, which confirmed what we had witnessed clinically, diffuse cerebral swelling with herniation. Over the following hospital days, the patient remained intubated with no neurological function except spontaneous breaths and pupils remaining fixed and asymmetrically dilated. I cannot medically explain how, but on hospital day 4, I saw the patient twitch a toe, then on day 5 witnessed eyelid fluttering.

Now, days and weeks later, the patient is awake, talking, requiring no pulmonary support, and eating real food. There are still many neurological deficits, but the patient has somehow made a meaningful recovery. When reflecting on this probably once in a lifetime experience, I know I have grown, both clinically and as a person. I still cannot medically explain how this patient is living, nor can I fully wrap my mind around the series of events that caused the medical chain of events. I do know that everyone involved in this patient's care did everything right, or I wouldn't have been told by the patient weeks after the event that, "I love you". Thinking about this still brings tears to my eyes, but this is just another reminder that though we think so, we are not always in control of what life brings. As medical providers, at all levels of care, we truly are the luckiest people around, as we get to touch and be touched by the lives of so many…and that's just our job.

2009 Maine EMS Awards Nomination Form Available Now

The Maine EMS Awards are presented each year in May during EMS Week and are conferred upon those individuals or groups that have demonstrated an exceptional level of commitment to EMS and EMD in Maine.

If you know of an individual, group, EMS service or EMD Center that has gone above and beyond the call of duty, please take time to fill out an awards nomination form and submit it to Maine EMS for consideration.

Visit www.maine.gov/dps/ems to download the 2009 awards nomination form. Award nominations must be received by Maine EMS no later than March 15, 2009.

A list of the 2008 Maine EMS Awards recipients is also available at www.maine.gov/dps/ems.

Report of Final Actions

Taken by the Maine EMS Investigations Committee

This notice is written in accordance with direction of the Maine EMS Board that the names, violations, and final disciplinary actions involving licensees who were subject to a fine, suspension, reprimand, requested voluntary surrender, and or revocation of their EMS licenses and or I/C certification be published in the Maine EMS Journal as a public notice.

The information listed in this section reflects the final action(s) taken by the Maine EMS Board. This information does not include pending actions or cases under appeal. This information does not contain, nor does it reflect, all of the factors involved in determining the final action, such as the severity of the misconduct/violation, the licensee's criminal and disciplinary history, or other mitigating factors. This publication is not intended as a guide to the level of disciplinary actions for a particular violation or misconduct, but rather as a publication that will increase awareness, reduce repetitive investigations, identify potential problem areas, and assist in determining areas for improvements in the quality and delivery of EMS statewide.

2008

Name: Joseph Yamello (EMS # 15613)
Violation: Patient care issues; Maine EMS Rules Chapter 11§(1)(5)
Action: Mr. Yamello entered into a Consent Agreement for Voluntary Surrender of MEMS License
Date: September 3, 2008

Name: John Wright (EMS # 15613)
Violation: Patient care issues; Maine EMS Rules Chapter 11§(1)(5), (21) and (22)
Action: Mr. Wright entered into a Consent Agreement for Voluntary Surrender of MEMS License.
Date: September 3, 2008

Name: NorthEast Mobile Health Services (EMS # 488)
Violation: Allowing an unlicensed provider to provide patient care; Maine EMS Rules Chapter 11 §(34) .
Action: NorthEast Mobile Health Services entered into a Consent Agreement for a fine of $200.00 and requiring them to monitor expiration dates of employees on an on-going basis and sending all employees a 45 day reminder notice.
Date: September 3, 2008

Name: Wayne Rescue (EMS # 985)
Violation: Non-compliance with submitting monthly run records to MEMS and non-compliance with Regional Quality Assurance (QA).
Action: Wayne Rescue entered into a Consent Agreement for 2 years to remain compliant with submitting monthly run records and with Regional QA, If non-compliant, Licensee will immediately surrender any license issued by Maine EMS pending resolution of any EMS investigation into the conduct unless Licensee can show good cause why the license should continue pending the investigation.
Date: November 5, 2008

Name: John Beyer (EMS # 18552)
Violation: Unlicensed provider; Maine EMS Rules Chapter 11 §(1)(30) and 32 M.R.S.A. §82(1).
Action: Mr. Beyer entered into a Consent Agreement which imposed a reprimand and a fine of $550.00 the total of which will be suspended.
Date November 5, 2008

Name: South Portland Fire Rescue (EMS # 655)
Violation: Allowing an unlicensed provider to provide patient care; Maine EMS Rules Chapter 11 §(34) .
Action: South Portland Fire Rescue entered into a Consent Agreement which imposed a reprimand and a fine of $2,200.00 with all but $550.00 suspended; require that Licensee follow the policy in place to prevent unlicensed providers responding on their behalf, and to provide MEMS an affidavit within one month that all runs were billed appropriately.

Best wishes to a valued EMS colleague

For the past 3 years, Ben Woodard has been the face and voice behind the Maine EMS Run Reporting System (MEMSRR). When Ben started at Maine EMS in 2005, we had finished the process to review different software options and made the decision to begin implementation of MEMSRR on January 1, 2006.

One of his first meetings at Maine EMS was an eye-opening experience as many people voiced their concern about how this conversion would affect them. Ben's approach was a patient and encouraging one that helped allay these concerns by providing personal interest and attention to every question.

Ben developed Policies and Procedures that answered the most common questions that arose and provided the guidelines for converting from paper to MEMSRR. Then over the following months produced several newsletters, conducted training sessions statewide, and answered a never-ending stream of questions (the most common being from those who forgot their login name and password).

It has been under Ben's guidance that MEMSRR went from brand new to widely accepted. A project that started with a few services in January 2006 has over 70% participation as this is being written (in early December), and we anticipate 100% compliance in accordance with the regulations in the coming weeks.

Ben is leaving our office on January 2, to begin his new career as the Chief Ranger at Baxter State Park.

For those of us who know Ben, we can appreciate what a wonderful opportunity this is for him as he has considerable experience working in the outdoors as a Ranger in both New York and Alaska, as the Executive Director of Wilderness Medical Associates and with L.L. Bean prior to joining the MEMS staff.

He leaves MEMS with our heartfelt thanks for what he has accomplished during his time here, which includes over 225,000 runs entered into MEMSRR, widespread for the importance of this new system, and with many of those who were the most concerned at the outset now among the most vocal supporters.

Thanks Ben.

MAINE EMS TEAM LEADERS

Ever wondered who to call when you have a question, complaint, concern or compliment about your EMS system? Listed below are the members of the Maine EMS Board, Maine EMS Staff, and the Regional Coordinators and Medical Directors. Each and every EMS team member in Maine is encouraged to get involved with how your system is run. So get involved—give us a call!

Maine EMS Board Members

Southern Maine EMS Rep	Ron Jones, EMT-P	23 Sterling Drive, Westbrook, ME 04092	TEL: 854-0654
Kennebec Valley EMS Rep	Tim Beals, EMT-P	PO Box 747, Waterville, ME 04903	TEL: 872-4000
Aroostook EMS Rep	James McKenney, EMT-P	229 State Street, Presque Isle, ME 04769	TEL: 768-4388
Tri-County EMS Rep	Lori Metayer, RN, EMT-P	3 Woodland Avenue, Lisbon Falls, ME 04252	TEL: 353-4546
Northeastern EMS Rep	Paul Knowlton, EMT-P	274 Pearl Street, Bangor, ME 04401	TEL: 941-5100
Mid-Coast EMS Rep	Steven E. Leach, EMT-P	PO Box 894, Union, ME 04862	TEL: 785-2260
Physician Rep	Peter DiPietrantonio, DO	4 Picnic Hill Road, Freeport, ME 04032	TEL: 373-2220
Nurse Rep	Geneva Sides, RN	PO Box 287, St. Albans, ME 04971	TEL: 487-5141 x269
First Responder Service	Richard Doughty, EMT-P	4153 Union Street, Levant, ME 04456	TEL: 941-5900
Emergency Medical Dispatch	James E. Ryan, Jr.	62 Main Trail, Hampden, ME 04444	TEL: 570-3773
For Profit Service	VACANT		
Not For Profit Service	Bob Hand, EMT-P	100 Hill Street, So. Paris, ME 04281	TEL: 890-6350
State Medical Control Director	Steven E. Diaz, MD	Maine EMS, 152 State House Station, Augusta, ME 04333	
Hospital Rep	Judy Gerrish, RN	891 West Main Street, Suite 400, Dover-Foxcroft, ME 04426	
Municipal EMS Service Rep	Wayne Werts, EMT-P, Chief	Auburn Fire Department, 550 Minot Avenue, Auburn, ME 04210	TEL: 783-6931
Fire Chief Rep	Roy Woods, Chief	Caribou Fire Department	
Public Rep	VACANT		
Public Rep	Ken Albert, Esq., RN	12 South Ridge Lane, Lewiston, ME	TEL: 777-5200

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REGION 1 — Donnell Carroll, Southern Maine EMS Council — Dr. Anthony Bock, Medical Director
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REGION 2 — Joanne LeBrun, Tri-County EMS Council — Dr. Kevin Kendall, Medical Director
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REGION 3 — Rick Petrie, EMT-P, KVEMS Council — Dr. Tim Pieh, Medical Director
71 Halifax Street, Winslow, ME 04901
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REGION 5 — Steve Corbin, Aroostook Maine EMS — Dr. Jay Reynolds, Medical Director
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REGION 6 — Bill Zito, Mid-Coast EMS — Dr. David Ettinger, Medical Director
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